PRIVATE HEALTH INSURANCE QUESTIONNAIRE

CASE NO.: _____

SETS NO.: _____

Section A
Personal Information

_____
PRINT NAME (☐ **Mother** ☐ **Father**)

_____
Street

_____
City **State** **Zip Code**

(____)_____
Home Telephone Number

(____)_____
Cell Phone Number

Check ALL applicable boxes and fill-in ALL blanks.

☐ **My child(ren) is/are covered by low-income government-assisted health care coverage (Healthy Start/Medicaid, etc.)**

Section B
List of Plans

I have the following **private health insurance** policies, contracts or plans to cover the child(ren) available to me.

Name of policy, contract or plan	Name of Insurance Company	Entity/group through which policy, contract or plan is available

Section C
No Private Health Insurance

☐ I **DO NOT HAVE** the child(ren) enrolled in **private health insurance** because:

- ☐ health insurance **is not available** through my employer or another group policy, contract or plan that will cover the child(ren).
- ☐ I **declined enrollment** of the child(ren) in health insurance available through my employer or another group policy, contract or plan, but **I am enrolled in a policy, contract or plan for myself.**
- ☐ I am **not yet eligible** to enroll in private health insurance through employment or another group policy, contract or plan, but I will become eligible on (month/day/year) ____/____/_____
- ☐ I expect to enroll the child(ren) when I become eligible.
- ☐ Other reason the child(ren) is/are not enrolled (explain): _____
  _____

Section D
Current Private Health Insurance Enrollment

☐ I **DO HAVE** the child(ren) enrolled in **private health insurance** through:

- ☐ an **individual (non-group)** policy, contract or plan.
- ☐ a **group** policy, contract or plan.

Date child(ren) was/were enrolled in private health insurance: (month/day/year) ___/___/___

Provided through: ☐ Employer ☐ Current Spouse ☐ Other: _____

Name of policyholder: _____
Policyholder Address: _____
_____
Policyholder Phone No.: (____)_____
Name of policy, contract or plan: _____

Insurance Co. Name: _____
Insurance Co. Claims Address: _____
_____
Insurance Co. Claims Phone No: (___)_____
Group Number: _____
Identification/Subscriber Number: _____

Section E
Accessibility of primary care service

My child(ren) has/have primary care services (health care/laboratory services customarily provided by a general practitioner, internal medicine, family medicine physician, or pediatrician) **accessible with this private health insurance:**

☐ within **30 miles** of the child(ren)'s home.

☐ because the child(ren) **live(s)** in a geographic area where the residents customarily travel farther than 30 miles for their child(ren)'s primary care services.

☐ because primary care services are **only accessible by public transportation**. (Primary care services are accessible by public transportation and the person responsible for taking the child(ren) for primary care service is dependent upon public transportation).

Section F
Reasonableness of cost / best interest of children considerations

The cost for private health insurance benefits that cover me and/or my child(ren) or will cover us when I am eligible is: (Do not include the amount that an employer or other person/entity pays for health insurance.)

Single coverage	$_____per month
Single coverage plus one	$_____per month
Single coverage plus two	$_____per month
Family coverage (unlimited dependents)	$_____per month
Other (explain): _____	$_____per month

☐ I want to enroll/continue to have the child(ren) enrolled in the private health insurance plan in which I am currently enrolled/will become eligible to enroll in **even if the cost exceeds 5% of my TOTAL ANNUAL GROSS INCOME** (Health Insurance Maximum).

Number of Dependents currently enrolled or who will be enrolled when I become eligible: _____

Name of Dependent	Relationship to You
_____	_____
_____	_____
_____	_____
_____	_____

In addition to my premium for private health insurance I must pay the following:

Annual Deductible:	$_____	Office Visits:	$_____
Prescriptions:	$_____	Urgent Care:	$_____
Emergency Rm.:	$_____	Other: _____	$_____

Type of Coverage: ☐ PPO ☐ HMO ☐ Traditional (unrestricted providers) ☐ Other: _____

My private health insurance covers the following services:

☐ Doctor's Office Visits	☐ Hospital Room & Board	☐ Home Health Care
☐ Emergency Care	☐ Mental Health In-patient	☐ Mental Health Out-patient
☐ Medical Supplies	☐ Substance Abuse Care	☐ Durable Medical Equipment
☐ Prescription Drugs	☐ Diagnostic Testing	☐ Laboratory
☐ Surgery	☐ 2nd Surgical Opinion	☐ Skilled Nursing Home
		☐ Other: _____

Attach a copy of all participant cards, prescription cards, and summary plan descriptions.

Section G
Certification

I, _____(print name), certify that the information I have provided on this PRIVATE HEALTH INSURANCE QUESTIONNAIRE is true and accurate to the best of my knowledge.

_____ _____

Date Questionnaire completed (month/day/year) **Signature (☐ Mother ☐ Father)**